

Insurance Fraud Investigations Unit
State of Hawaii Insurance Division
Suspected Fraudulent Claim (SFC) Referral Form

PRINT OR TYPE

Please refer to instructions when completing
this form; you may call #586-2790 if further
assistance is required.

Please mail or deliver to:

Insurance Fraud Investigations Unit
State of Hawaii Insurance Division
250 S. King St., 5th flr.
P.O. Box 3614
Honolulu, HI 96811-3614

Fraud Code: _____ Complaint Type: _____
Case ID#: _____ Insurance Company Entity ID#: _____
☐ Main Case ☐ Subsequent Case. Main Case ID#: _____

(Insurance Fraud Investigations Unit Use Only)

FRAUD TYPE: ☐ Vehicle Theft ☐ Vehicle Arson ☐ Vehicle PD ☐ Personal Injury Protection
☐ Bodily Injury ☐ Staged Accident ☐ Other _____

COMPLAINANT NAME: _____

(A company or person such as an Insurance Co., Self-Insured, Third Party Adjuster, Law Enforcement Agency, Witness, Informant, etc..)

Claim # _____ Date of Loss/Injury _____ Location of Loss/Injury _____

ADDRESS: _____ City _____ State _____ Zip _____

CONTACT PERSON/FILE HANDLER: _____ Telephone # (____) _____

(Please check appropriate boxes)

ACTUAL LOSS AMOUNT

POTENTIAL LOSS AMOUNT

☐ COLLISION

☐ COMPREHENSIVE

☐ PROPERTY DAMAGE LIABILITY

☐ PERSONAL INJURY PROTECTION

☐ UNINSURED MOTORIST

☐ BODILY INJURY LIABILITY

☐ OTHER _____

INCIDENT/CLAIM REPORTED TO OTHER AGENCY: (Please check appropriate boxes.)

☐ Other Law Enforcement Agency (Name) _____

☐ NICB ☐ AICD (Auto Only) ☐ Index System ☐ Other _____

☐ YES ☐ NO ☐ N/A Has this claim been settled with the SUSPECT?

If yes, when was the claim settled? _____ and how much was it for? _____

☐ YES ☐ NO Has the SUSPECT been notified of this case referral?

☐ YES ☐ NO Has the SUSPECT been made aware of the initiation of a fraud investigation by your company?

☐ ATTACHMENT(S) (Attach items documenting the suspected fraud activity described in the instructions.)

(Print) Name: _____ Position or Title: _____

Signature _____ Date: _____

Important: Please provide prompt notification to this office of any subsequent action taken on this case such as
settlement of the claim, denial of the claim or notice to suspect of fraud investigation or of this case referral.

Case ID#: _____

Insurance Company Name: _____

(Insurance Fraud Investigations Unit Use Only)

A. POLICYHOLDER

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID# _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN# _____
(Year, Make, Model)

Insurance Company Name _____ Pol/Claim #- _____

Date of Loss/Injury _____ Location of Loss/Injury _____

aka's _____

dba's _____

B. SUSPECT

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID # _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN# _____
(Year, Make, Model)

aka's _____

dba's _____

OTHER PARTIES INVOLVED IN THE LOSS

C. *Relationship of Party to the Loss _____

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID # _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN# _____
(Year, Make, Model)

aka's _____

dba's _____

Case ID #: _____

Insurance Company Name: _____

(Insurance Fraud Investigations Unit Use Only)

(ADDITIONAL) PARTIES INVOLVED IN THE LOSS

D. *Relationship of Party to the Loss _____

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID # _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN # _____
(Year, Make, Model)

aka's _____

dba's _____

E. *Relationship of Party to the Loss _____

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID # _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN # _____
(Year, Make, Model)

aka's _____

dba's _____

F. *Relationship of Party to the Loss _____

Name: _____ Home Phone # (_____) _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (zip)

Employer Name: _____ Position _____

Address _____ Business Phone # (_____) _____

DOB/Age _____ SSN _____ Tax ID # _____

Drivers License # _____ State _____

Vehicle _____ License Plate # _____ State _____ VIN# _____
(Year, Make, Model)

aka's _____

dba's _____